DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

MENTAL HEALTH RESIDENTIAL TREATMENT COST REPORT EXEMPTION FORM

Cost Report Due Date: JANUARY 31, 2008

PLEASE COMPLETE AND SUBMIT IF EXEMPT

This completed form MUST be submitted in order to request exemption.

Federal Tax ID: _____ ***REQUIRED**

Corporate Name: _____

Address: _____City/State/Zip: _____

Phone Number: (____)_____ Fax Number: (____)_____

NPI and related Medicaid Provider Numbers: _____ _____

_____ _____ _____

_____ _____ _____

Please attach additional sheets if more space is needed for NPI and related Medicaid Provider #s.

We are requesting exemption from the 2008 Mental Health Residential Treatment Cost Report due to: [Indicate appropriate reason/s]

_____ was not in business for **at least 6 months** in the reporting period.

_____ filed the 2007 or will file the 2008 **Residential Treatment and Foster Care Cost Report** due to the DHHS Office of the Controller.

_____ filed or will file the **2007 Mental Health Cost Report** due to the DHHS Office of the Controller.

_____ does not meet the Medicaid minimum dollar threshold of **$230,000** per Agency **Federal Tax ID#** in revenue generated from providing Medicaid Residential Treatment Services. This threshold has been established based on cumulative revenue by Tax ID. For multi-facility agencies, combine the revenue for all individual facilities to determine if you meet the minimum dollar threshold.

_____ _____
(Date) (Authorized Signature for the Provider Agency)

_____
(Printed name of person signing above)

Return completed form via email, fax, or mail to:
N.C. Division of Medical Assistance
Attention: Deidra Oates
Financial Operations
2501 Mail Service Center
Raleigh, NC 27699-2501
Fax: (919)715-2209
Email: deidra.oates@ncmail.net